SECTION V.3. Assessment & Reassessment Procedures

I. Initial Assessment Procedures

After the Department of Disabilities, Aging and Independent Living (DAIL) staff determines clinical eligibility and sends Clinical Authorization to DCF and Transitional Service Plan to providers, a comprehensive assessment must be completed in order to develop a Service Plan for ongoing Choices for Care (CFC) services. The assessment procedure is determined by the following CFC settings:

A. Home-Based Initial Assessment

1. **Case manager**, together with the individual, shall complete a full assessment (ILA) within 14 calendar days of receipt of the Clinical Certification.

2. The **case manager** shall ensure that a registered nurse completes the Health Assessment portion of the ILA.

3. The **case manager**, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

4. The **case manager**, together with the individual, shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.

5. The **case manager**, together with the individual, shall identify, if any, the informal/family supports that will continue.

6. The **case manager**, together with the individual, shall review the service options and service limitations with the individual, surrogate, and/or guardian.

7. The **case manager**, together with the individual shall select services and develop a comprehensive Service Plan with the individual that is appropriate to the identified needs, and in compliance with existing CFC service definitions, standards, procedures, and limitations.

8. The **case manager** shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.

9. The **case manager** shall sign the Service Plan.

10. The **case manager** shall review and complete an "In-Home Back-up Care & Emergency Plan" form with the individual. The plan shall be posted in an obvious location within the individual's home.

11. The **case manager** shall compile and submit a complete assessment package to DAIL.

12. The **case manager** shall ensure that the package is complete, containing the following documents:

a. Proposed Service Plan
b. Personal Care Worksheet
c. Independent Living Assessment (ILA)
d. Assistive Devices and Modifications Addendum (if applicable)
e. Employer Certification Form (if applicable for consumer/surrogate-directed only)
f. Variance request(s) (if applicable)
g. Adult Family Care Agreement (if applicable)

13. **DAIL staff** shall return incomplete initial assessment packets to the case manager.

14. The **case manager** shall assist the applicant with the CFC financial eligibility application when necessary. The Department for Children and Families (DCF) financial eligibility forms shall be completed as soon as possible after Clinical Certification has been made.

15. The **case manager** shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or consumer).

16. The **case manager** and **providers** shall follow procedures for "Initiating Services".

17. **DAIL staff** shall complete Utilization Review (UR).

18. **DCF staff** shall complete CFC financial eligibility and send notice to individual, provider and DAIL.

19. **DAIL staff** shall verify CFC financial eligibility.

20. If the individual meets the financial eligibility criteria, **DAIL staff** shall authorize the initial Service Plan, including any adjustments as determined in the UR process.

21. **DAIL staff** shall mail approved Service Plan to the individual, case manager and providers.

22. **DCF staff** shall mail a denial letter with appeal rights, to individuals do not meet the CFC financial eligibility criteria. A copy of the denial notice will be send to DAIL staff.

B. Enhanced Residential Care (ERC) Initial Assessment

1. The **ERC provider**, together with the individual, must complete a full resident assessment within 14 calendar days of receipt of the Clinical Certification, or admission (whichever comes first) together with the case manager whenever possible.

2. The **ERC provider** shall ensure that a registered nurse completes or signs-off on the assessment.

3. The **Licensed Level III Residential Care Home** that is an ERC provider must submit a variance request to the Division of Licensing and Protection (DLP) for permission to serve or retain the individual if they have reached their pre-approved variance amount.

4. The **ERC provider** shall provide a copy of the resident assessment to the case manager.

5. The **case manager** shall complete an ERC Tier worksheet and ERC Service Plan.

6. The **case manager** shall obtain the signature of the applicant or legal representative on the Service Plan.

7. The **case manager** and the **ERC provider** shall sign the Service Plan.

8. The **case manager** shall compile and submit a complete assessment package to DAIL.

9. The **case manager** shall ensure that the package is complete and contains the following documents:
   a. Proposed Service Plan
   b. Tier Worksheet
   c. Comprehensive Resident Assessment (CRA)
   d. Written Justification for Dual Participation in Hospice (if applicable)
   e. Variance Request Form (when applicable)

10. **DAIL** shall return incomplete initial assessment packets to the case manager.

11. The **case manager** shall assist the applicant with the VT CFC financial eligibility application when necessary. The Department for Children and Families (DCF) financial eligibility forms shall be completed as soon as possible after Clinical Certification has been made.

12. **DAIL** shall complete Utilization Review (UR).

13. **DLP** shall send a copy of the variance approval to DAIL (*Licensed Level III only*).

14. The **Department for Children and Families** (DCF) shall complete LTC Medicaid financial eligibility and send notice to individual, provider and DAIL.

15. **DAIL** shall verify CFC financial eligibility and DLP variance status.

16. **DAIL** shall authorize the initial Service Plan, including any adjustments as determined in UR process.

17. **DAIL** shall mail approved Service Plan to the individual, case manager and providers.

18. **DCF staff** shall mail a denial letter with appeal rights to individuals who do not meet the CFC financial eligibility criteria. A copy of the denial notice will be send to DAIL staff.

19. **DAIL** shall send a denial letter with appeal rights to individuals who are denied a variance by DLP.

20. The **ERC provider** shall follow procedures for “Initiating Services”.

C. Nursing Facility (NF) Initial Assessment

1. The **NF provider**, together with the individual, shall complete the Minimum Data Set (MDS) according to existing State and Federal nursing facility regulation.

2. The **NF provider** shall assist the applicant with the CFC financial eligibility application when necessary. The Department for Children and Families (DCF) financial eligibility forms shall be completed as soon as possible after Clinical Certification has been made.

3. **DCF staff** shall complete CFC financial eligibility and send notice to individual, NF provider and DAIL.

4. The **NF provider** shall follow procedures for "Initiating Services" and shall develop individual service plans for all residents, in compliance with prevailing conditions of participation and licensing regulations.

5. **DCF staff** shall mail a denial letter with appeal rights to individuals do not meet the LTC Medicaid financial eligibility criteria. A copy of the denial notice will be send to DAIL staff and NF provider.

II. Reassessments Procedures

Individuals participating in CFC services must have a comprehensive reassessment completed on a regular basis. The reassessment procedure is determined by the following CFC settings:

A. Home-Based Reassessment

1. The **case manager**, together with the individual, shall complete a full reassessment (ILA) at least once every 365 days. The reassessment must be completed, submitted and received at DAIL prior to the previous plan of care end date.

2. The **case manager**, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

3. The **case manager**, together with the individual, shall identify the service options which will address the individual's unmet needs and for which the individual is eligible.

4. The **case manager** shall identify, if any, the informal/family supports that will continue.

5. The **case manager** shall review the service options and service limitations with the individual, surrogate, and/or guardian.

6. The **case manager**, together with the individual, shall select services and develop a comprehensive Service Plan with the individual that is appropriate to the identified needs, and in compliance with existing CFC service definitions, standards, procedures, and limitations.

7. The **case manager** shall ensure that a registered nurse completes the Health Assessment portion of the ILA.

8. The **case manager** shall obtain the signature of the applicant and surrogate (when applicable) on the Service Plan.

9. The **case manager** shall sign the Service Plan.

10. The **case manager** shall compile and submit a complete reassessment package to DAIL.

11. The **case manager** shall ensure that the package is complete, containing the following documents:
    a. Proposed Service Plan
    b. Personal Care Worksheet
    c. Independent Living Assessment (ILA)
    d. Assistive Devices and Modifications Addendum (if applicable)
    e. Employer Certification Form (if applicable for consumer/surrogate-directed only)
    f. Variance request(s) (when applicable)
    g. Adult Family Care Agreement (if new or different)

12. **DAIL staff** shall return incomplete reassessment packets to the case manager

13. The **case manager** shall assist the applicant with the Long-Term Care Medicaid financial eligibility reviews when necessary.

14. The **case manager** shall distribute a copy of the Personal Care Worksheet to the personal care attendant (PCA) employer (Home Health Agency, surrogate, or consumer).

15. **DAIL staff** shall complete Utilization Review (UR).

16. **DAIL staff** shall authorize the Service Plan, including any adjustments as determined in UR process.

17. **DAIL staff** shall mail approved Service Plan to the individual, case manager and providers.

B. Enhanced Residential Care (ERC) Reassessment

1. The **ERC provider**, together with the individual, must complete a comprehensive resident reassessment (CRA) at least once every 365 days, together with the case manager whenever possible. The reassessment must be completed, submitted and received at DAIL prior to the previous plan of care end date.

2. The **ERC provider**, together with the individual, shall assess the individual's circumstances, resources, strengths and needs.

3. The **ERC provider** shall ensure that a registered nurse completes or signs-off on the reassessment.

4. The **ERC provider** shall provide a copy of the CRA to the case manager.

5. The **case manager** shall complete an ERC Tier worksheet and ERC Service Plan.

6. The **case manager** shall obtain the signature of the applicant or legal representative on the Service Plan.

7. The **case manager** shall sign the Service Plan.

8. The **case manager** shall compile and submit a complete reassessment package to DAIL.

9. The **case manager** shall ensure that the package is complete, containing the following documents:
   a. Proposed Service Plan
   b. Tier Worksheet
   c. Comprehensive Resident Assessment

10. **DAIL staff** shall return incomplete reassessment packets to the case manager.

11. The **case manager** shall assist the applicant with the Long-Term Care Medicaid financial eligibility reviews when necessary.

12. **DAIL staff** shall complete Utilization Review (UR).

13. **DAIL staff** shall authorize the Service Plan, including any adjustments as determined in UR process.

14. **DAIL staff** shall mail approved Service Plan to the individual, case manager and providers.

C. Nursing Facility (NF) Reassessment

1. The **NF provider**, together with the individual, shall complete the Minimum Data Set (MDS) and individual service plan in compliance with prevailing conditions of participation and licensing regulations.

2. The **NF provider** shall assess the individual's circumstances, resources, strengths and needs.

3. The **NF provider** shall assist the applicant with the Long-Term Care Medicaid financial eligibility review when necessary.

III. Dual Program Participation Assessment Procedures

A. Attendant Services Program

Only individuals granted a variance by DAIL may participate in both CFC services and the Attendant Services Program (ASP). If DAIL approves the individual to participate in both programs, the following assessment procedures apply:

1. The **case manager** shall coordinate and complete assessments together with the State RN assessor for the ASP.

2. The **State ASP assessor** shall complete the Health and Functional Assessment sections of the Independent Living Assessment (ILA) and a dual participation Personal Care Worksheet.

3. The **case manager** shall complete the CFC Service Plan to include the personal care hours from the Personal Care Worksheet as completed by the **State ASP assessor**, as well as all other necessary CFC forms.

4. The **case manager** must contact the State RN assessor prior to any plan of care change to determine whether a dual assessment is necessary.

5. The **State ASP assessor** shall ensure that a copy of the ILA assessment is forwarded to the case manager immediately upon completion.

6. Once the ILA is received, the **case manager** will follow the process for submitting complete assessment packets to DAIL.

7. **DAIL staff** shall complete utilization review and clinical eligibility determinations.

8. **DAIL staff** shall authorize the Service Plan in coordination with the State ASP assessor and ASP review committee.

B. Hospice Program

Individuals participating in the Choices for Care program who become eligible for, and in need of Home Health Hospice services may do so without prior authorization from DAIL. It is the understanding of both DAIL and the Home Health hospice providers that dual participation will occur under the following conditions:

1. Hospice staff will inform the Medicaid Waiver case manager immediately when a Medicaid Waiver participant is admitted to hospice.

2. Individuals must continue to meet the criteria for both Medicaid Waiver and hospice services.

3. When ever possible, hospice funded services must be maximized and utilized prior to waiver services (e.g. LNA, Homemaker).

4. The cost of Medicaid Waiver services will not increase after admission to hospice services.

5. When appropriate, the waiver case manager will submit a plan of care change to reflect any reduction in waiver personal care time for activities that are being provided by hospice (e.g. bathing, grooming).

6. It is the responsibility of the local home health agency to contact DAIL no later than one week after the individual is admitted to hospice services. DAIL will track the following information:

- Participant name,
- Agency name,
- Hospice diagnosis,
- Anticipated length of hospice service,
- Hospice admission date,
- Payment source,
- Hospice contact,
- Copy of Hospice plan.

This information may be mailed or faxed to DAIL.